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Coping with chemotherapy for breast cancer: Asking women what works

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ABSTRACT

Purpose: To explore the coping strategies women use to cope with the side effects and distress of chemotherapy for breast cancer.

Methods: Twenty women with breast cancer who received chemotherapy took part in qualitative, semi-structured face-to-face interviews about their coping strategies. Ten women had received their diagnosis via a national breast cancer screening programme, and ten women had been diagnosed through referral to a symptomatic breast cancer services clinic. Data was analysed using thematic analysis based on an interpretative phenomenological approach.

Results: A combination of coping strategies were utilised to deal with the side effects of chemotherapy, with three main themes emerging. *Behavioural coping* strategies such as anticipatory coping and maintenance of activities were used to regain a sense of control. *Emotional coping* strategies such as seeking support and reappraisal were utilised to cope with treatment-related distress. Women also engaged in *coping appraisal*, whereby women evaluated how effective their responses were in reducing their distress, often leading to a change in the coping strategies used. Women who were diagnosed through the screening programme were less likely to seek treatment information or access cancer support services.

Conclusions: Anticipating side effects and engaging in coping strategies to minimise their impact highlights the importance of providing accurate information about the side effects of treatment, and the potential for these strategies as components of effective interventions to reduce distress. Oncology nurses are ideally placed to drive provision of pre-chemotherapy care programmes that include specific preparatory information to increase adaptive coping, and reduce distress.

1. Introduction

Chemotherapy is one of the most stressful aspects of a breast cancer diagnosis, with up to 90% of patients reporting some level of distress (Costanzo et al., 2007). It can lead to poor functioning and fatigue post-treatment (Buick et al., 2000; Fan et al., 2005), as well as greater depression, anger, and mood disturbance (Hack et al., 2010). Much of the distress surrounding chemotherapy stems from the experiences of side effects. The response to treatment is individualistic; and while some side effects are common, their frequency and severity vary considerably.

Numerous interventions focusing on such strategies as stress management and cognitive behavioural training (Antoni et al., 2001; Matthews et al., 2017) have aimed to reduce distress and increase optimal coping strategies in women with breast cancer. However, these interventions teach women coping strategies that are considered to be generally adaptive, rather than focusing specifically on strategies that have been identified by participants as being most beneficial when responding to a specific aspect of an illness, such as chemotherapy. A more co-ordinated approach to their preparatory care during this time is required. Although some studies have assessed coping during chemotherapy (Bussell and Naus, 2010; Manne et al., 1994; Shapiro et al., 1997), they tend to use quantitative methods to measure generic coping styles. Even studies that have used a combination of questionnaires and open-ended questions do not explore the strategies women specifically used to cope with chemotherapy (Waldrop et al., 2011). Qualitative research is needed in this context, as questions can be tailored to how women respond to specific side effects of treatment such as fatigue (Magnusson et al., 1999) or hair loss (Frith et al., 2007; Zannini et al., 2012). The current study seeks to understand the subjective experience of women coping with chemotherapy treatment. More women are being diagnosed through national breast cancer screening programmes, and some research suggests that there are differences in the experiences and levels of distress of these women, compared to those who had a lump or

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other symptom of breast cancer and were diagnosed through referral from a GP or other healthcare professional to a dedicated cancer clinic service (Gibbons et al., 2017).

1.1. Aim of study

The main aims of this study were to explore the types of coping strategies women use to deal with the side effects and distress of chemotherapy and to assess differences in coping in women based on the method of detection of their disease. A better understanding of these coping approaches will inform development of more tailored interventions in the future.

2. Methods

Interpretive phenomenological approach (IPA) was employed in this qualitative study. IPA focuses on how people make sense of their world and explores their perceptions of events and situations (Smith and Osborn, 2003). It has been used in many contexts and is particularly useful for answering research questions that relate to how people make sense of their world and experiences. This paper reports on the experiences of 20 women who received chemotherapy as part of their treatment for breast cancer. Ten women were diagnosed and recruited via a national breast cancer screening programme, and ten women were diagnosed and treated through symptomatic breast cancer clinics after being referred from their general practitioner for a lump or other breast symptom.

2.1. Setting and sample

A purposive sample of participants were invited to take part. Eligible women were identified and recruited from two longitudinal studies examining predictors of distress in women with breast cancer that were being run at a university hospital. Women from two clinics were recruited; 1) those who received their diagnosis and treatment through symptomatic breast cancer clinics after being referred from their general practitioner for a lump or other breast symptom, and 2) women who received their diagnosis and treatment through the national breast cancer screening service. Women from the screening programme previously took part in a larger quantitative study of 94 women examining distress in women diagnosed with breast cancer (Gibbons et al., 2016), whilst those who were recruited from the symptomatic clinic were a subsample of the 253 women who took part in a three-year longitudinal study examining stress, distress, and post-traumatic growth (Groarke et al., 2017). For each group, women were eligible to take part if they had a confirmed diagnosis of breast cancer, had completed outpatient chemotherapy within the previous 12 months, were aged 18 years or over, and were fluent in English. See Table 1 for a summary of demographic and medical characteristics of the sample. The mean age of participants was 53.60 years (SD = 7.74, range 38–65 years). All respondents were Anglo-Saxon in their cultural background. All women had either stage II or III breast cancer and were interviewed an average of 10.5 months after completing their chemotherapy (range 5–12 months). Eleven women received 4 sessions of Taxotere and Cyclophosphamide (TC) chemotherapy, whilst the remaining nine women received 8 sessions of Adriamycin-Cyclophosphamide, Taxol (AC-T) chemotherapy. At interview, thirteen women were still receiving some form of treatment for their breast cancer, such as radiotherapy or hormone treatment.

Table 1
Summary of demographic and medical variables of women interviewed.

Variable	M	SD	Range
Age (years)	53.60	7.74	38–65
Time since diagnosis (months)	20.45	11.49	9–48
Time since completed chemotherapy (months)	10.50	2.63	5–12
Number of chemotherapy sessions	6.00	2.42	4–12

Variable	*N*	%
Marital status		
Single	1	5.00
Married	17	85.00
Separated	1	5.00
Widowed	1	5.00
Employment		
Part-time employment	6	30.00
Full-time employment	5	25.00
Working in the home	6	30.00
Retired	1	5.00
No employment	2	10.00
Method of cancer detection		
Screening programme	10	50.00
Symptomatic – self-referred	10	50.00
Diagnosis		
DCIS	2	10.00
IDC	6	30.00
IDC and DCIS	4	20.00
ILC/ILC and LIN	3	15.00
Mixed carcinoma	5	25.00
Stage of disease		
Stage IIA, IIB	13	65.00
Stage IIIA, IIIB	7	35.00
Surgery		
Lumpectomy	14	70.00
Mastectomy without reconstruction	3	15.00
Mastectomy with reconstruction	3	15.00
Radiation therapy: yes	16	80.00
Hormone therapy: yes	17	85.00
Still receiving treatment: yes	13	65.00
Type of chemotherapy		
TC (Taxotere and cyclophosphamide)	11	55.00
AC-T (Adriamycin-cyclophosphamide, Taxol)	9	45.00

2.2. Data collection

The study was approved by the University and Hospital Research Ethics Committees (REF 11/JAN/01). Permission to conduct the study was provided by the lead breast surgeons in the hospital. All participants were informed that their data would be kept confidential and anonymous in any analyses. They were also free to withdraw at any time. In both groups, eligible women were identified by the breast care nurses within the breast cancer clinics in the university hospital and invited to take part in the quantitative studies. Those who provided consent to take part in the study, also indicated their willingness to be contacted for a sub-study that involved a qualitative interview about their treatment. Information about the study, along with contact details of the researcher, was sent to eligible women once they had received their chemotherapy from March 2011 to June 2012. A total of 50 women (25 screen detected, 25 symptomatic group) were invited to take part over this fifteen-month period. These women were randomly selected from all eligible women to take part as they fulfilled the inclusion criteria (completed chemotherapy within the past 12 months, were fluent in English) during this time. Three women declined to participate, and 3 women were too ill to be interviewed. A sample of at least 15 participants was sought based on recommendations from previous research (Francis et al., 2010; Guest et al., 2006). After 17 interviews, a consistent pattern of responses was established, indicating saturation had been achieved. However, data collection was extended until an equal number of women with screen-detected disease (n = 10) and symptomatic breast disease had participated (n = 10). Those who agreed to participate and returned the consent forms were contacted via phone, and a time was arranged to conduct the interview.

All interviews were conducted by the first author and took place at the convenience of the participants, either within their home (n = 15) or in a private room in the university (n = 5). Those who were interviewed in the university were attending medical appointments in a